APPLICATION FOR PHYSICAL THERAPIST OR PHYSICAL THERAPIST'S ASSISTANT (To Practice In The State Of Indiana)

State Form 9111 (R10 / 12-02)
Approved by State Board of Accounts, 2003

Health Professions Bureau
402 W. Washington St., Rm. 041
Indianapolis, IN 46204
(317) 234-2051
Email address: hpb6@hpb.state.in.us

***Your Social Security number is being requested by this state agency in accordance with I.C. 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.**

Application fee	
Date fee paid (*month, day, year*)	
Receipt number	
Application number / License/Certification number	
License/Certification issuance date (*month, day, year*)	

Temporary permit fee
Date fee paid (*month, day, year*)
Receipt number
Temporary permit number
Temporary permit issuance date (*month, day, year*)

APPLICANT

Attach two (2) passport type quality photographs of yourself taken within the last eight weeks. Please sign each photo at the bottom. Negatives and Polaroids are not acceptable.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle, maiden*)		Social Security number*
Address (*number, street or Rural Route*)		
(*City, state, ZIP code*)		Email address
Telephone number (*daytime*)	Date of birth	Birth place

BASIS FOR LICENSURE

Please check appropriate box

☐ Examination ☐ Endorsement

Please check appropriate box

☐ Physical Therapist ☐ Physical Therapist's Assistant

Have you previously filed an application for licensure/certification by examination or endorsement as a Physical Therapist or Physical Therapist's Assistant in Indiana or any other state?

☐ Yes ☐ No (*If "Yes", please give details as to where and when*)

Have you previously taken the licensure or certification examination for Physical Therapy or Physical Therapist's Assistant? (*If yes, please list date and place*)

☐ Yes ☐ No

Have you previously failed the licensure or certification examination in Indiana or any other state?

☐ Yes ☐ No (*If "Yes", please give details as to where and when*)

TEMPORARY PERMIT

Do you desire a temporary permit?

☐ Yes ☐ No

PHYSICAL THERAPIST / PHYSICAL THERAPIST'S ASSISTANT DEGREE GRANTED BY

Name of school	Location	Date of graduation (*Month, day, year*)

UNDERGRADUATE AND GRADUATE TRAINING

NAME OF SCHOOL	LOCATION	FROM MONTH/YEAR	TO MONTH/YEAR	DEGREE

List all states, including Indiana, in which you have been licensed or certified to practice any regulated health profession.

STATE	TYPE OF LICENSE OR CERTIFICATE	NUMBER	DATE ISSUED	CURRENT STATUS

PLACES OF EMPLOYMENT SINCE GRADUATION

NAME AND ADDRESS OF EMPLOYER	RESPONSIBILITIES	DATE

PLACES YOU HAVE LIVED SINCE GRADUATION

GENERAL LOCATION	DATE

NOTE: If your answer is "Yes" to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location and date. If malpractice, provide name(s) of plaintiff(s). Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a license, certification or permit issued pursuant to this application.

1.	Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held?	☐ Yes	☐ No
2.	Have you ever been denied licensure, registration or certification in any state (*including Indiana*) or country?	☐ Yes	☐ No
3.	Are you now, or have you ever been treated for a drug abuse or an alcohol problem?	☐ Yes	☐ No
4.	Have you ever been charged with drug addiction?	☐ Yes	☐ No
5.	Have you ever been convicted of, plead guilty to or nolo contendre to any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*)	☐ Yes	☐ No
6.	Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations?	☐ Yes	☐ No
7.	Have you ever been admonished, censored, reprimanded or requested to withdraw, resign or retire from any hospital or health care facility in which you have trained, held staff membership or privileges or acted as a consultant?	☐ Yes	☐ No
8.	Have you ever had a malpractice judgement against you or settled any malpractice action?	☐ Yes	☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm, under the penalties of perjury, that the statements made in this application are true, complete and correct.

Signature of applicant	Date (*month,day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for physical therapy licensure or physical therapist's assistant certification.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned organizations, persons, and institutions any information which is material to my application and I hereby specifically release the Bureau and the Committee from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Date (*Month, day, year*)	Signature of applicant